

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Borsaard

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

12085

Reg. Dist. No.

21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

ARUNDEL

City or town

ANNAPOLIS, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 HRS.

Hospital, Institution, or street address where death occurred:

EMERGENCY HOSPITAL

How long in hospital or institution? 7 HRS.

3. (a) FULL NAME

GERTRUDE EVERETT BALDWIN

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

RICHARD BALDWIN

7. Birth date of deceased (mo., day, yr.)

MAY 16, 1868

6. (c) If alive, give age years

8. AGE: Years

80

Months

6

Days

19

If less than one day

hrs.

min.

9. Birthplace

NEW YORK CITY
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name

WILLIAM M. EVERETT

13. Birthplace

MD.

14. Maiden name

GEORGINA KELLEY

15. Birthplace

N.Y.

16. Informant

C. C. BALDWIN

Address

808 14th ST So. ARLINGTON Va

17. BURIAL
(Burial, cremation, or removal. Which?)

Date thereof
(month) (day) (year)

Cemetery or crematory

BALDWIN MEMORIAL

Location

MILLERSVILLE, MD.

18. Funeral director

HENRY W. JENKINS & SONS

Address

4905 YORK RD. BALTO 12

19. Date rec'd by registrar

Dec 6 1948

19 48

A.W. Hinch

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

MD.

County

ARUNDEL

City or town

ANNAPOLIS

(If outside city or town limits, write RURAL and give nearest town)

Street No.

CARVEL HALL

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 5

1948 at 12 45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19 44 to Dec 5 1948

and that I last saw her alive on

Dec 5 1948

1948

Immediate cause of death

cardiovascular

failure and collapse

DURATION

7 hrs

Due to

Arteriosclerotic condition -
vascular disease &
hypertension

Due to

15 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Borsaard M.D.

M. D. or other

Address

Annapolis Md

Date signed

12/15/48

Borsnick

answ same # at Brookl ave 2760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12686

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Pearl Bauer

7. Birth date of deceased (mo., day, yr.)

Janv 19, 1895.

6. (c) If alive, give age 54 years

8. AGE: Years

53

Months

11

Days

2

If less than one day

hrs.

min.

9. Birthplace

Sykesville, Carroll Co., Maryland

(Town, county, and state)

10. Usual occupation

Garage man

11. Industry or business

U. S. Naval Academy

MOTHER FATHER

12. Name

John H. Bauer

13. Birthplace

Belair, Harford Co., Maryland

14. Maiden name

Ella E. Stagmer

15. Birthplace

Belair, Harford Co., Maryland

16. Informant

Mrs. Pearl Bauer

Address

226 Main St. Annapolis, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 12/23/48

(month) (day) (year)

Cemetery or crematory

Cedars Bluff

Location

Annapolis Md

18. Funeral director

T. J. Hardisty & Son

Address

Belleville Md

19. Date rec'd by registrar

Dec. 22, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Anne Arundel

City or town

Annapolis

Street No.

226 Main

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 21, 1948 at 1⁰⁰ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Postmortem Examination and that I last saw him alive on Dec. 21, 1948

Immediate cause of death

Auto cardiac failure

Due to Chronic Cardis - vascular disease

Date of about 4 years

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

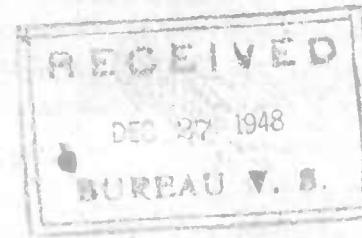
Injured at work?

23. SIGNATURE

M. D. or other

John M. Gaffy, M.D. Deputy Medical Examiner

Annapolis, Maryland Date signed 12-21-48



2 PIECES OF EVIDENCE
CHANGE OF AGE SHOWN ON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Bc

12087

28

1. FLM No. G 118 JAN 19 1949
2. FLM No. 118 JAN 19 1949

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

Anne Arundel
County
Crownsville
City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years, 15 mos. 28 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 11 years, 15 mos. 28 days

3. (a) FULL NAME

BLANCHE BISHOP

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FEMALE Colored

single

6.(b) Name of husband or wife

none

6.(c) If alive, give age.....years

7. Birth date of deceased (mo. day, yr.)

18%
58 57

8. AGE: Years

Months

Days

If less than one day

? ? ? hrs. min.

9. Birthplace

Maryland town unknown

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

none

MOTHER FATHER

12. Name

John Bishop

13. Birthplace Maryland town unknown

14. Maiden name

Julia Cook

15. Birthplace

Maryland

16. Informant Hospital Records

Address Crownsville, Maryland

17. Burial Date thereof 1/1-49
(Burial, cremation, or removal. When?)

(month) (day) (year)

Cemetery or location

Crownsville Md

Location

Crownsville Md

18. Funeral director

Address Bishop Hospital

Address

Crownsville Md

19. 1/1/

1949

87 Joyce Local

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. unknown

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 12/16/48 1948 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/18/37 1937 to 12/16/48 1948

and that I last saw her alive on 12/16/48

Immediate cause of death Hypertensive

Cardio-Vascular Disease

DURATION

known to us since

9/18/37

Due to

Due to

Other conditions Chronic Alcoholism

Epilepsy

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

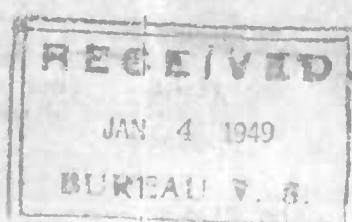
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jacob Mungester M.D.

M. D. or other

Address Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61 Be
1208828

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Anne Arundel

County

Crownsville

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7/12/48

Hospital, Institution, or street address where death occurred:

Crownsville State Hos pital

How long in hospital or institution? 5 ms 13 days

3. (a) FULL NAME

LUCY LEE BLAKE

4. Sex

FEMALE

5. Color or race

COLORED

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Frank Bla ke

6.(c) If alive, give age .. years

7. Birth date of deceased (mo., day, yr.)

3/4/1878

8. AGE: Years

70

Months

9

Days

21

If less than one day

hrs.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name James Woods deceased

13. Birthplace Blacksburg Va

14. Maiden name Sarah Woods deceased

15. Birthplace Blacksburg Va.

16. Informant Hospital-records

Address

Crownsville State Hospital

17. Burial Date thereof 12/30/48

(month) (day) (year)

Cemetery or crematory Mt Auburn

Location

Balt. Md

18. Funeral director Chas. H. Cooper

Address

572 Carrollton Ave

19. 12/30

(Date rec'd by registrar)

19

XP Adm Redick

Dm

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Baltimore

1069 Argyle Ave. Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25/48 19 at 0910

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/12/48 19 to 12/25/48 19

and that I last saw her alive on 12/25/48

Immediate cause of death

myodegeneratio cordis
cerebral arteriosclerosis
moderate diabetes

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

M. D. or other

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12089

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Anne Arundel

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

200 Benton Ave

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Caroline Vergenea Brown

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

White Widow

6. (b) Name of husband or wife

William L. Brown

7. Birth date of deceased (mo., day, yr.)

July 20 - 1873

(b) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Howard, Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Randolph Young

Howard Co., Md.

12. Name

Sarah F. Johnson

Howard Co., Md.

13. Birthplace

Anchorage, Alaska, U.S.A.

14. Maiden name

Sarah F. Johnson

Howard Co., Md.

15. Birthplace

Anchorage, Alaska, U.S.A.

16. Informant

Address Anchorage, Alaska, U.S.A.

17. Burial

(Burial, cremation, or removal, which?) Date thereof DCE. 19. 1948

(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery, Md.

Location

Brooklyn, Md. R.F.D.

18. Funeral director

Thomas W. Dugan

Address

Glen Burnie, Md.

19. 12/27

(Date rec'd by registrar)

19. 48

Date signed

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Anne Arundel

City or town Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No. Hammond's Ferry Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

December 25 48 at 8:30 A.M.

2D. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to December 25 1948 and that I last saw her alive on 1/22/48.

Immediate cause of death

Medical In sufficiency

DURATION

3 yrs

Due to Interstitial nephritis

3y

Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

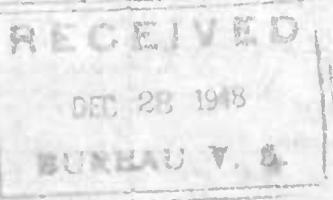
23. SIGNATURE

Ernest H. Pauchard

M. D. or other

Address

Glen Burnie, Md. Date signed 12/25/48



I

9-45-1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12090

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Anne Arundel Co.
City or town Eastport, near Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years

Hospital, institution, or street address where death occurred: 611 Second Street

How long in hospital or institution?

3. (a) FULL NAME

Mary Elizabeth Brown

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

Colored

Married

Columbus C. Brown

6.(b) Name of husband or wife

6.(c) If alive, give age 85 years

7. Birth date of deceased (mo. day, yr.)

June 27, 1876

8. AGE: Years

Months

Days

If less than one day

72

4

7

hrs.

min.

baltimore, Maryland

9. Birthplace

(Town, county, and state)

Housewife

10. Usual occupation

11. Industry or business

None

Benjamin Brown

FATHER

12. Name

Anne Arundel Co. Maryland

13. Birthplace

unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

Florence Scott

16. Informant

354 W. Biddle St. Balto., Md.

Address

Burial Date thereof 12-8-1948

17.

(Burial, cremation, or removal. Which?)

Mt. Auburn

(month) (day) (year)

Cemetery or crematory

West Port, near Baltimore, Md.

Location

18. Funeral director

Mrs. Charles E. Hicks

Address

43-45 Northwest Street

19.

Dec. 8, 1948

(Date rec'd by registrar)

m. French

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel Co.

City or town Eastport, near Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 611 Second Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

Dec 4

18 48 425 M

20. DATE OF DEATH

Nov 16 47 120c 4 19 48

and that I last saw her alive on Dec 4

Immediate cause of death

Congestive heart failure

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. Adams

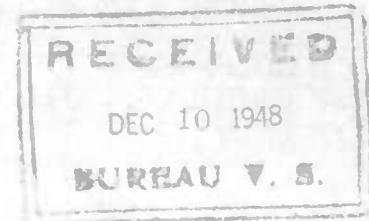
Address

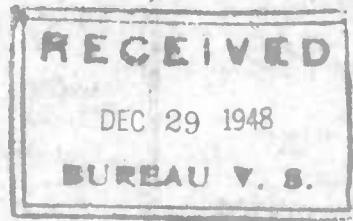
10 Grand

M. D. or other

12-7-48

Date signed





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

121.92

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County..... Anne Arundel County
 City or town..... RURAL DORSEY MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George William Cavey

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife. Frances M. Cavey

7. Birth date of deceased (mo., day, yr.)

April 8 1873

6. (c) If alive, give age 69 years

8. AGE: Years

Months

Days

If less than one day

75

8

9

hrs.

min.

9. Birthplace.....

Howard Co. Maryland
(Town, county, and state)

10. Usual occupation

Store cutter (retired)

11. Industry or business

Fzekial A. Cavey

FATHER

12. Name.....

Maryland

MOTHER

13. Birthplace.....

Rebecca Tacey

14. Maiden name.....

West Virginia

15. Birthplace.....

Frances M. Cavey

16. Informant.....

Race Road Dorsey Maryland

17. Burial

Date thereof..... 12-20-48
(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

M. Oliver - Randallstown

Location

Randallstown, Md.

18. Funeral director

John J. Tickner & Son

Address

Baltimore, Md.

19. Date rec'd by registrar

Dec 20 1948

A. W. Helms
88

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel

City or town..... Rural Dorsey Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No..... Race Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Dec. 17 1948 at 12¹⁵ p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on Dec. 17 to Dec. 17 1948
 and that I last saw him alive on Dec. 16 1948

Immediate cause of death.....

Cardiac thrombosis
DURATION 17 daysDue to..... Cardiac - vascular disease
2 yrs.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) (County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Sam S. Bellingslea, M.D.

M. D. or other

Address..... Glen Burnie, Md. Date signed..... Dec 18, 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12693

CERTIFICATE OF DEATH

28

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Grundel

City or town Crownsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

10/13/45

How long in above place of death?

Hospital, Institution, or street address where death occurred: Crownsville High

3 years 2 months

How long in hospital or institution? 3 years 2 months

3. (a) FULL NAME

WILLIAM CURRY

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	NEGROE	unknown

6.(b) Name of husband or wife..... unknown

7. Birth date of deceased (mo. day, yr.) (unknown) ABT. 1888

8. AGE: Years	Months	Days	It less than one day
60(?)	(?)	(?)	hrs. min.

9. Birthplace..... (Town, county, and state)

10. Usual occupation..... unknown

11. Industry or business..... unknown

MOTHER FATHER 12. Name..... unknown

13. Birthplace..... unknown

14. Maiden name..... unknown

15. Birthplace..... unknown

16. Informant..... Hospital Records

Address Crownsville, Md.

17. (12/16-45) burial Date thereof. 12-16-48
(Burial, cremation, or removal, which)

Cemetery or repository Hospital Cemetery

Location Crownsville, Md.

18. Funeral director..... Super of Hospital

Address Crownsville, Md.

19. 12/13 1948 E. F. Joyce, D.D.S.

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... unknown County..... unknown

City or town..... unknown (If outside city or town limits, write RURAL and give nearest town)

Street No..... unknown

2.(a) If veteran, name war..... unknown

3. (b) Social Security Number

MEDICAL CERTIFICATION

12/13/48

19. 48

at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/13/45

and that I last saw him alive on 12/13/48

Immediate cause of death..... General Arteriosclerosis

DURATION

known to us since 10/13/45

Due to.....

Due to.....

Other conditions..... degeneration of myocard

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

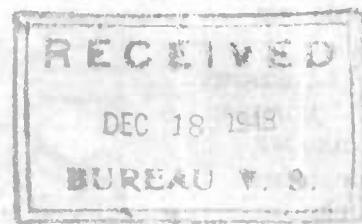
Injured at work?

23. SIGNATURE

M. D. or other

Address..... Date signed.....

60
1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

126.94
1952 CD

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County Anne Arundel

City or town Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Station Hospital Ft Geo G. Meade, Md.

How long in hospital or institution?
25 hours

3. (a) FULL NAME

CHARLES AUGUSTUS DEAKIN

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife..... Mary Deakin
6. (c) If alive, give age..... Unk years

7. Birth date of deceased (mo., day, yr.) 1 September 1922

8. AGE:	Years	Months	Days	It less than one day
	26	3	17	hrs. min.

9. Birthplace.....
(Town, county, and state)

10. Usual occupation..... Soldier US Army

11. Industry or business..... Unknown

12. Name.....	13. Birthplace.....
Unknown	

14. Maiden name.....	15. Birthplace.....
Unknown	

16. Informant.....	17. Removal.....	Date thereof.....	Dec 18 48
Mary Deakin	(Burial, cremation, or removal. Which?) Cemetery	(month) (day) (year)	

Location.....	Injured at home, farm, industry, public place (where?)
Danbury, Conn	Army Post

18. Funeral director.....	Means of injury.....
Lilly & Zeiler Inc	Grenade explosion

Address.....	Injured at work? Yes
1901-1907 Eastern Ave, Balt., Md.	

22 Dec 48	19. (Date rec'd by registrar)	James P. Goerner	JAMES N. GOERNER, CAPT., FT G G MEADE MD
-----------	-------------------------------	------------------	--

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Conn County Fairfield

City or town Danbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 75 Garfield Ave

(If rural, give LOCATION)

2. (a) If veteran, name war..... World War #2

3. (b) Social Security Number
* * *

MEDICAL CERTIFICATION

18 December

19. 48 al 1300 hrs

20. DATE OF DEATH..... 17 December 19. 48 to 18 December 19. 48

and that I last saw h. im. alive on 18 December 19. 48

Immediate cause of death..... Severe brain damage

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations..... Subdural hematoma, right.

Date of op. 17 Dec 48

Autopsy results..... Pending

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident..... Accident Date of 17 Dec 48

Accident, suicide, or homicide.....

Where did injury occur? Ft Meade A.A. Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Grenade explosion

Injured at work? Yes

23. SIGNATURE..... Allen G. Thomas

ALLEN G. THOMAS, CAPT., M. D. or other MC

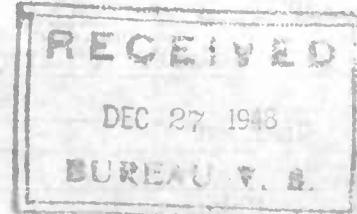
Address..... FT G G MEADE MD

Date signed 22 Dec 48

111-98-59 THE UNITED STATES GOVERNMENT

THE FEDERAL BUREAU OF INVESTIGATION

Washington, D.C.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12695
93d
21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel

County.

Glen Burnie.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

HARRY T. DONALDSON

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife Bertha A. Donaldson

Nee Shuele

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo. day yr.) June 28, 1875

8. AGE: Years Months Days It less than one day
73 5 15 hrs. min.9. Birthplace Anne Arundel County, Md.
(Town, county, and state)

10. Usual occupation Contractor (Retired)

11. Industry or business Construction

12. Name Robert Donaldson

13. Birthplace Anne Arundel County, Md.

14. Maiden name Elizabeth J. Davis

15. Birthplace Anne Arundel County, Md.

16. Informant Mrs. Bertha A. Donaldson

Address 7 Second Ave. S.W. Glen Burnie,

17. Burial Date thereof Dec. 17, 1948
(Burial, cremation, or removal. Which?)

Cemetery or crematory Glen Haven

Location Glen Burnie, Md.

18. Funeral director Thomas W. Singleton

Address Glen Burnie, Md.

19. 12/13 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7 Secone Ave S.W.

(If rural, give LOCATION)

none

2.(a) If veteran, name war.....

3. (b) Social Security Number

213 01 9462-A

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 1948, at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 19, 1948, to Dec 13, 1948

and that I last saw her alive on Dec. 13, 1948

Immediate cause of death

Coronary Thrombosis

DURATION

1 hours

Due to Coronary Vasculair Disease

3 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane of injury

Injured at work?

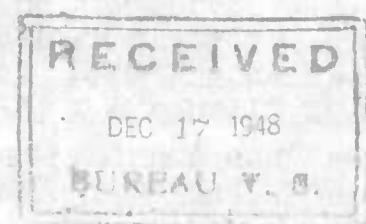
23. SIGNATURE

James S. Buckingham M.D.

M. D. or other

Address Glen Burnie, Md. Date signed Dec 13, 1948

Registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12696
84b

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel County

City or town Crownsville State Hospital

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years, 7 mos. 2 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 14 years, 7 mos. 2 days

3. (a) FULL NAME

BESSIE DORSEY

4. Sex

Female

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

married

B. (b) Name of husband or wife

Alfred Pendleton

8. (c) If alive, give age ** years

7. Birth date of deceased (mo., day, yr.)

ABT. 1907

8. AGE:

Years 46

Months ?

Days ?

If less than one day *** hrs. *** min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Farmwork

11. Industry or business

none

MOTHER FATHER

12. Name

Nick Dorsey

13. Birthplace

Maryland

14. Maiden name

Susie Anna Queen

15. Birthplace

Maryland

16. Informant

Hospital Records

Address

Crownsville State Hospital

17. burial

(Burial, cremation, or removal. Which?)

Date thereof 12 / 48

(month) (day) (year)

Cemetery or crematory

Mount Tabor

Location

Chesterfield, Md.

18. Funeral director

William Reese, II

Address

108 Washington St., Annapolis, Md.

19. December 3 1948

(Date rec'd by registrar)

Edgar L. Love

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel

City or town Millersville

(If outside city or town limits, write RURAL and give nearest town)

Street No. none

(If rural, give LOCATION)

2.(a) If veteran, name war ****

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1948 19.48 at 5:00AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28, 1934 19.34 to Dec. 1 19.48

and that I last saw her alive on Dec. 1, 1948 19.48

Immediate cause of death Exhaustion

Due to

Due to

Other conditions Dementia Praecox

(Include pregnancy within 8 months of death)

Major findings of operations ****

Date of op.

Autopsy results ****

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ****

Date of

Where did injury occur? ****

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

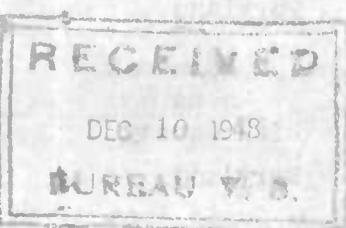
Injured at work

23. SIGNATURE

M. D. or other

Crownsville State Hospital

Date signed 12/1/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12097

CERTIFICATE OF DEATH

93d
Reg. Dist. No. 21

1. PLACE OF DEATH:
 County Anne Arundel
 City or town Parole, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Turner Dorsey
 male Negro Single

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day. yr.)

6. (c) If alive, give age years

November 30, 1905

8. AGE:

Years	Months	Days	It less than one day
43			

 hrs. min.

9. Birthplace

Portland, Md.

(Town, county, and state)

10. Usual occupation.

Labor

11. Industry or business

Nick Dorsey

MOTHER FATHER

12. Name

Maryland

13. Birthplace

Suzie Anne Queen

14. Maiden name

Maryland

15. Birthplace

Mrs. Sarah Bradford

16. Informant

Parole, Md.

Address

17. Burial

Date thereof 1-3-49
 (Burial, cremation, or removal. Which?)

Cemetery or crematory

Mt. Tabor

Location

Chesterfield, Md.

18. Funeral director

William Reese, II

Address

108 Washington St. Annapolis, Md.

19. Date rec'd by registrar

Jan 3 1949

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Anne Arundel
 City or town Parole, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 31 1948 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 5 1948 to Dec 31 1948
 and that I last saw him alive on Dec 30 1948

Immediate cause of death

Hypertension Cardio-
 vascular disease,

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

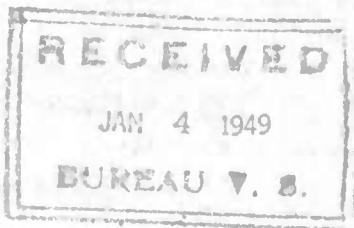
Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed Jan 3 1949







PRINT PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46b
12099
20

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Benjamin Durall Jr.

3. (b) Social Security Number

4. Sex

male

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Irene Durall

6. (c) If alive, give age years

55

7. Birth date of deceased (mo., day, yr.)

Apr. 13. 1893

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Owensville, A. A. County, Maryland

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Farm

MOTHER FATHER

12. Name

Benjamin Durall Jr.

13. Birthplace

A. A. County, Maryland

14. Maiden name

Isabel Durall

15. Birthplace

A. A. County, Maryland

16. Informant

Irene Durall

Address

West River, Maryland

17. Burial

Date thereof: Dec. 18. 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Daniel Star Cemetery

Location

Baltimore Md.

18. Funeral director

S. P. Murphy & Son

Address

Owensville, Maryland

19. (Date rec'd by registrar)

1948

1948

D.M.C.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Anne Arundel

City or town

Owensville

Street No.

R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 5. 1948 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Postmortem Examination

and that I last saw him alive on

Dec. 5. 1948

Immediate cause of death

Carcinoma of Stomach

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

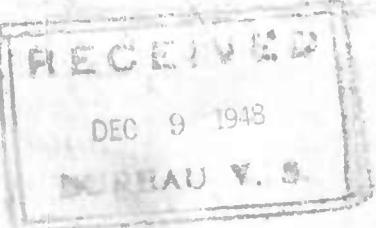
Injured at work?

23. SIGNATURE

John M. Coffey M.D. Medical Examiner
Minneapolis, Minn. M.A. or other

Date signed

12-5-48



M
A
R
K

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

121000

CERTIFICATE OF DEATH

84d
28

Reg. Dist. No.

1. PLACE OF DEATH:
 County Anne Arundel County
 City or town Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 yrs 16 days
 Hospital, Institution, or street address where death occurred: Crownsville State Hospital
 How long in hospital or institution? 3 yrs 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1906 Lauretta Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war. ✓

3. (a) FULL NAME

ETHEL RAY EDEMY

4. Sex F	5. Color or race Negro	6. (a) Single, married, widowed, or divorced Widowed	
6. (b) Name of husband or wife Unknown			
7. Birth date of deceased (mo. day, yr.)	6. (c) If alive, give age dead years		
1896			
8. AGE: Years 52?	Months	Days	If less than one day
			hrs. min.

9. Birthplace Maryland
 (Town, county, and state)
 Housework

10. Usual occupation
 11. Industry or business
 12. Name Joseph T. Ray
 MOTHER FATHER 13. Birthplace Maryland

14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Hospital Records

Address Crownsville, Maryland
 17. Burial Date thereof July 7-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Calvary
 Location Brooklyn, N.Y.
 18. Funeral director J. E. Brooks & Son

Address 1463 N. Carey St
 Date rec'd by registrar Dec. 4 1948
 E. F. Joyce
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1948, 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 17, 1945, to December 3, 1948, and that I last saw her alive on December 3, 1948.

Immediate cause of death
 Catatonic Exhaustion
 Known to us since

Due to: _____
 Duration 11/17/48

Due to: _____
 Other conditions Involutional Psychosis
 Known to us since 11/17/45
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of _____

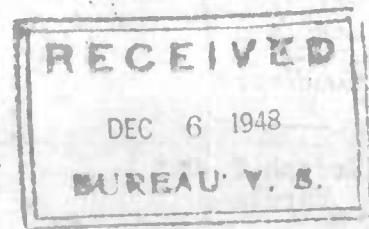
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work? _____

23. SIGNATURE: Jacob Marguerite, M.D.
 M. D. or other

Address Crownsville, Maryland Date signed 12/3/48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

410
928

12101

1. PLACE OF DEATH:

County A.A.

City or town Jessups

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? four(4) weeks

Hospital, institution, or street address where death occurred:

Maryland House of Correction

How long in hospital or institution? 24 days

3. (a) FULL NAME

James A. Fearson

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1884

8. AGE: Years Months Days If less than one day
64 1 19 hrs. min.9. Birthplace Centerville, Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Maryland House Correction,

Record

Address Jessups, Md.

17. BURIAL Date thereof 1-4-49
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CHESTERFIELD

Location CENTERVILLE, MD

18. Funeral director JOHN T. STANSBURY

Address 2700 EDMONDSON AVE.

19. Died 1948 at Clara Hospital
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Ann. Arundel

City or town Jessups (If outside city or town limits, write RURAL and give nearest town)

Street No. Maryland House of Correction

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31, 1948, at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 7, 1948, to Dec. 31, 1948,

and that I last saw him alive on Dec. 30, 1948.

Immediate cause of death Congestive heart failure

DURATION 4 weeks

Due to Mitral insufficiency

Due to

Other conditions Arterio-sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John A. Clark M.D. M. D. or other

Address On H.E. Jessup Rd Date signed 12-31-48

11-11-4881

b1
b4
c6
1941-241



THE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12102
28

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since 11/21/47

Hospital, institution, or street address where death occurred.

Crownsville State Hospital

How long in hospital or institution? 1 year 1 month

3. (a) FULL NAME

Lucy Garner (Gorman)

4. Sex

5. Color or race

Female

Negro

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

unknown

unknown

6. (c) If alive, give age unknown years

7. Birth date of deceased (mo. day, yr.)

unknown A.B.T. 1888

8. AGE: Years

60 (?)

Months

?

Days

3

If less than one day

hrs.

min.

9. Birthplace

unknown

(Town, county, and state)

10. Usual occupation

unknown

11. Industry or business

unknown

MOTHER FATHER

12. Name

unknown

13. Birthplace

unknown

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Hospital Records

Address

Crownsville, Maryland

17. Burial, cremation, or removal. Which?

Burial

Date thereof

12/22/48

Cremation

(month) (day) (year)

Removal

Cemetery or crematory

Crownsville

Location

Hospital

18. Funeral director

Ange P. Hospital

Address

Crownsville, Md

19. Date rec'd by registrar

12/22/48

19

87 Joyce P.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State unknown County unknown

City or town unknown (If outside city or town limits, write RURAL and give nearest town)

Street No. unknown (If rural, give LOCATION)

2.(a) If veteran, name war unknown

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

12/17/48

19 48 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/21/47 19 48 to 12/17/48 19 48

and that I last saw her alive on 12/17/48 19 48

Immediate cause of death General Paresis

DURATION

known to us since 11/21/47

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Date

Means of injury

Injured at work

23. SIGNATURE

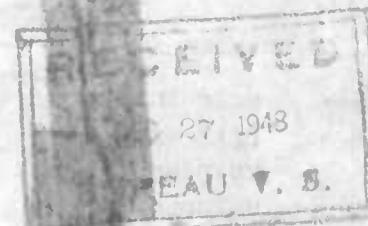
M. D. or other

Address Crownsville, Maryland

Date signed 12/17/48

1948
1988

600



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12103
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

ANNE ARUNDEL

County.....

Waterbury

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Addie Gray

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored Widow

Joseph Gray

B.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1870

8. (c) If alive, give age..... years

8. AGE: Years 78 Months 0 Days 7 If less than one day hrs. min.

9. Birthplace Washington D.C.

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name Lim Jackson

13. Birthplace Washington D.C.

14. Maiden name Unknown

15. Birthplace

Elizabeth Jones

16. Informant Address Crownsville, Md.

17. Burial

Burial, cremation, or removal. Which? Bury thereof Dec. 10, 1948

(month) (day) (year)

Cemetery or crematory Waterbury

Location Waterbury, Md.

18. Funeral director J.B. Johnson

Address Annapolis, Md.

19. Date rec'd by registrar Dec. 9 1948

(Date rec'd by registrar)

Effoye Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County A.A.Co.

City or town Waterbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6

19 48, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 1947 to Dec. 6 1948

and that I last saw her alive on Nov. 4 1948

Immediate cause of death

Hypertension & Arteriosclerotic Heart Disease

DURATION

2 years

Due to

Generalized Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

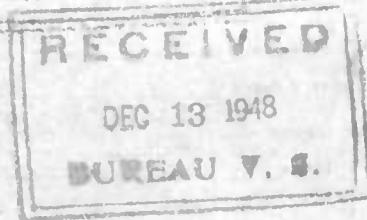
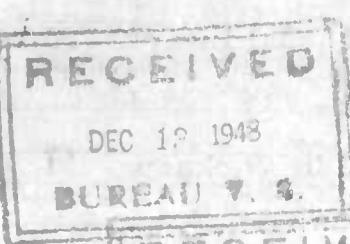
Means of injury

Injured at work?

23. SIGNATURE Edward J. O'Neill M.D.

M.D. or other

Address 6 Cambriills, Md. Date signed Dec. 8, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

12104

20

1. PLACE OF DEATH:

County..... *Jameson, Maryland*City or town..... *Deale, Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *69 years.*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Morris Hardesty.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

married.

6.(b) Name of husband or wife..... *Agnes Hardesty.*6.(c) If alive, give age *60* years7. Birth date of deceased (mo., day, yr.) *June 1879*8. AGE: Years *69* Months *6* Days *1* Less than one day *hrs. min.*9. Birthplace..... *Calvert County, Md.*

(Town, county, and state)

10. Usual occupation..... *Laborer.*

11. Industry or business

12. Name..... *James D. Hardesty.*13. Birthplace..... *Calvert County.*14. Maiden name..... *Sarah E. Hardesty.*15. Birthplace..... *Calvert County.*16. Informant..... *Robert C. Hardesty.*Address..... *Deale, Md.*17. Burial: Date thereof..... *Dec. 31 - 1948*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... *Deale Cemetery.*Location..... *Deale, Md.*18. Funeral director..... *Harry Hutchins -*Address..... *Owings - Md.*19. *12/29/48* (Date rec'd by registrar) *W. D. Clayton* (Signature)
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *Anne Arundel*City or town..... *Deale, Md.*

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war..... *no*

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *December 28 1948* at *11:30 P.M.*21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *August 10 - 1947 to Dec. 28 1948* and that I last saw him alive on *December 26 1948*Immediate cause of death..... *Cerebral thrombosis*

DURATION

Due to..... *arteriosclerosis - Cerebral**& general*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings at operations.....

Date of op.

Autopsy results..... *No*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... *No* Date of.....

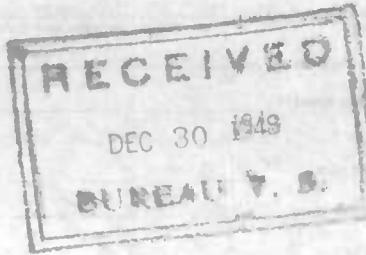
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... *Ernest H. Wilson, M.D.* M. D. or otherAddress..... *Collier, Md.* Date signed *12-29-48*

~~1879-6~~
1948-12-28



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12115

CERTIFICATE OF DEATH

Reg. Dist. No. 23

50

1. PLACE OF DEATH:

County

Baltimore County -
Box 116 Light St Rd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sex

Female white married.

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

George Harding

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.)

April 7, 1878

Years

Months

Days

If less than one day

70 8 22 hrs. min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

12. Name

Charles W. Riley

13. Birthplace

Md

14. Maiden name

Georganna Tracey

15. Birthplace

Md

16. Informant

Mr. George Harding

Address Box 116 Light St Rd

17. Burial

(Burial, cremation, or removal, which?)

Glen Burnie

Cemetery or crematory

Annapolis Blvd

Location

John F. Kennedy Ave

18. Funeral director

A. W. Heidrich

Address 115 Light St

Dec. 31 1948

(Date rec'd by registrar)

Q.S. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County AACo

City or town

Glen Burnie (If outside city or town limits, write RURAL and give nearest town)

Street No.

Box 116 Light St Rd (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29th 1948 at 3²⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

MAY 1946 to DECEMBER 1948

and that I last saw her alive on DEC 28 1948

Immediate cause of death CARCINOMA OF BREASTS

CARCINOMA OF BREASTS

Due to CARCINOMA OF BREASTS

Due to UNKNOWN

Other conditions HYPERTONIC, ESSENTIAL

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE X J. J. Zangara M.D.

M. D. or other

Address Glen Burnie Date signed 12/30/48

Hr Jangale
201 Balto Annagale
Balrd

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12106

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:
County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Rachel Harris

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Negro	Widowed

6. (b) Name of husband or wife	Mathaniel Harris
--------------------------------	------------------

7. Birth date of deceased (mo. day, yr.)	Feb. 13, 1887	8. (c) If alive, give age..... years
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8. AGE: Years	Months	Days	If less than one day
61	9	18	hrs. min.

9. Birthplace	Mt. Zion, Md.	(Town, county, and state)
---------------	---------------	---------------------------

10. Usual occupation.

11. Industry or business

12. Name	Allen Diggs
----------	-------------

13. Birthplace	Mt. Zion, Md.
----------------	---------------

14. Maiden name	Josephine Diggs
-----------------	-----------------

15. Birthplace	Mt. Zion, Md.
----------------	---------------

16. Informant	Sidney Davis
---------------	--------------

Address	1115 Chapel St. Norfolk, Va.
---------	------------------------------

17. Burial	Date thereof	12. 22. 48	
(Burial, cremation, or removal, Which?)	(month)	(day)	(year)

Cemetery or crematory	Galesville
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Location	Galesville, Md.
----------	-----------------

18. Funeral director	William Geesell
----------------------	-----------------

Address	108 Washington St. - Annapolis, Md.
---------	-------------------------------------

19. (Date rec'd by registrar)	12/22/48
-------------------------------	----------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1 Calvert Court
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1948 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 17, 1948, to Dec. 19, 1948,

and that I last saw her alive on December 19, 1948.

Immediate cause of death Hypertensive Cardio
Vascular Disease DURATION
2 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

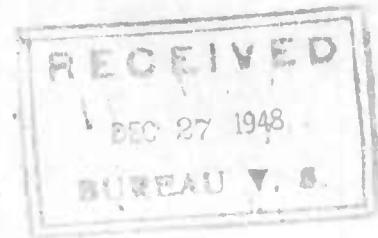
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address 40 Northgate Street Date signed 12/2/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12107

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County

City or town

*Wm Arnall
Glebe Heights, Edgewater*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 years

Hospital, institution, or street address where death occurred

How long in hospital or institution?

3. (a) FULL NAME

Lula W. Hooper,

4. Sex

female

5. Color or race

White

8. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Robert Hooper

6. (c) If alive, give age

64

years

7. Birth date of deceased (mo., day, yr.)

April 29 - 1889

8. AGE: Years Months Days If less than one day

59

7

9

hrs.

min.

9. Birthplace

Montgomery County, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

Own home

MOTHER FATHER

12. Name

Mr Weaver

13. Birthplace

not known

14. Maiden name

Rebecca Rogers

15. Birthplace

unknown

16. Informant

Robert Hooper

Address

Glebe Heights, Edgewater, Md

Burial

Burial

(Burial, cremation, or removal. Which?)

Date thereof: Dec. 10 - 1948

(Month) (day) (year)

Cemetery or crematory

Smithville Cem.

Location

Edgewater

18. Funeral director

C. A. Standiford Jr.

Address

Talleville Md.

19. Dec. 9 1948 Edward Collier

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*

County

City or town *Edgewater*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *Glebe Heights*

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 8 1948 at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated.

Postmortem Examination

and that the cause of death was

Dec. 8 1948

Immediate cause of death

Cerebral Accident

Due to

Cardio - renal hypertension

disease

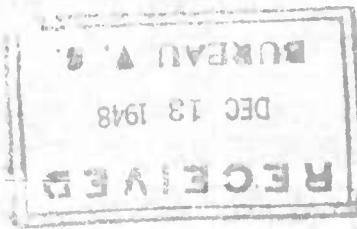
General arterio - sclerosis

Other conditions

Unknown

grave soil service
11 A.M.

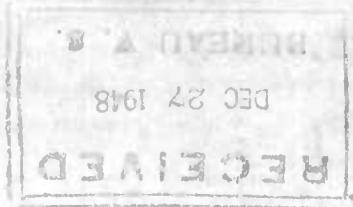
grave - - - 10.00



1948-72-
" 34
55-4229
1889-7-449

Charles H. Masters

1921 - 1948



1948
1868

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1910-21
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH		Anne Arundel Co.		2. USUAL RESIDENCE OF DECEASED:	Anne Arundel Co.		
(a) Baltimore City, Maryland				(a) State	Md.	(b) County	Jessup
(b) Street address		Jessup Md.		(c) City or town	Baltimore		
(c) Hospital or institution:				(If outside city or town limits, write RURAL and give town)			
(d) Length of stay in hospital or inst. (yrs., mos., or days)				(d) Street No.		(If rural give location)	
(e) Length of stay in Baltimore (yrs., mos., or days)				(e) Citizen of foreign country?		(Yes or No)	
3. (a) FULL NAME		Maggie Johnson		If yes, name country			
3. (b) If veteran, name war				3. (c) Social Security Account No.			
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.		MEDICAL CERTIFICATION			
Female	Col.	Widow		20. DATE OF DEATH		Dec 12 1948	at 8:45 AM
6. (b) Name of husband or wife		Benjamin		21. I certify that death occurred on the date above stated, that I attended deceased from		Nov. 11 1948	to Dec 12 1948
				and that I last saw her alive on		Dec 5 1948	
7. Birth date of deceased (mo., day, yr.)		Aug 11, 1886		Immediate cause of death		Pneumonia	
8. AGE: Years		Months	Days	If less than one day		Duration	
62				hr.		6 yrs	
9. Birthplace		Va.		Due to		Tuberculosis	
		(Town, county, and state)		Due to			
10. Usual Occupation		Housewife		Other Conditions			
11. Industry or business				PHYSICIAN			
12. Name		Nursed Persons		(Include pregnancy within 3 months of death)			
13. Birthplace		Va.		Date of operation			
14. Maiden Name		Eliza ?		Major findings of operation			
15. Birthplace		Va.		of autopsy			
16. (a) Informant		Lillian Mc Clellan		22. If death was due to external causes, fill in the following:			
(b) Address		Jessup Md.		(a) Accident, suicide, or homicide			
17. (a) Burial		(b) Date thereof 12/16/48		(b) Date of occurrence		at M	
(Burial, cremation, or removal)		(month) (day) (year)		(c) Where did injury occur?		(City or town) (County) (State)	
(c) Cemetery or crematory		Mt Calvary Cem.		(d) Did injury occur about home, on farm, industrial place, in public place?		While at work? (Specify type of place)	
Location		A.A. County Md		(e) Means of injury			
18. (a) Funeral director		Mrs Ruth J. Elliott, D.P.		23. Signature		M. D.	
(b) Address		1129 N. Caroline St					
19. (a) Date rec'd by registrar		12/14/48 PM		Address		Elkridge MD Date signed 12/14/48	
		Registrar					

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12111

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel
 City or town: Baltimore, Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Anne Arundel
 City or town: Belvedere Bch.

(If outside city or town limits, write RURAL and give nearest town)
 Street No: 10000 Block P.O.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

John Preston Jones

4. Sex

m

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day. yr.)

Jan 6 - 1909

8. AGE Years Months Days If less than one day

40

hrs.

min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business:

12. Name: John Jones

13. Birthplace: Md

14. Maiden name: Anna E. Chance

15. Birthplace: Md

16. Informant: Hospital

Address: Burial

17. Date thereof: Dec 23 - 48
 (Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory: Church Nec. Md

Location: Church Nec. Md

18. Funeral director: Edgar L. Lane

Address: Church Nec. Md

19. Date rec'd by registrar: 19

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 20 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 18 1948 to Dec. 20 1948

and that I last saw him alive on Dec. 19 1948

Immediate cause of death:

Cirrhosis of Liver

Due to: Alcoholism

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results: Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

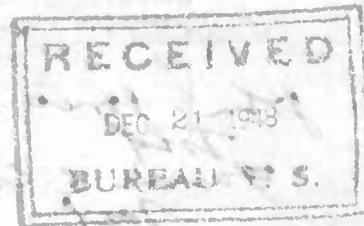
Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. J. Kavanagh, M.D.

M. D. or other:

Address: 318 Mt. Pleasant Av. Date signed: 1/2/1949



EVIDENCE FOR CHANGE
OF BIRTH DATE SHOWN ON MARYLAND STATE DEPARTMENT OF HEALTH

File No. G 118 DEC 29 1948

2411 N. Charles St., Baltimore

97

12112

Reg. Dist. No.

26

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Deale

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary E. Leatherbury

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

Wm Leatherbury

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar 23, 1868

8. AGE:

79

8

15

If less than one day

hrs. min.

9. Birthplace

Md

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

Robert Jennings

M

12. Name

Robert Jennings

M

13. Birthplace

Md

14. Maiden name

Ellen Stallings

M

15. Birthplace

Deale

16. Informant

Mrs Clarence Lovel

M

Address

Burial

Date thereof

Dec 11, 1948
(month) (day) (year)

(Burial, cremation, or removal, which?)

Cemetery or crematory

Treasers

Location

Md

18. Funeral director

H.A. Houghton & Son

Address

Salisbury Md

19. Date rec'd by registrar

Dec 11, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

A.A.

City or town

Deale

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

12/8

1948 at 11:45

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1 1948 to Dec 8 1948

and that I last saw her alive on Dec 8, 1948

Immediate cause of death

Arteriosclerosis

DURATION

5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

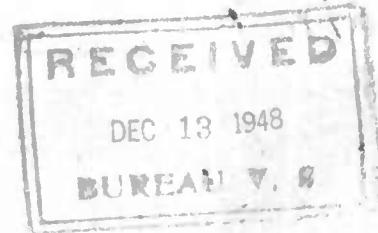
Means of injury

Injured at work?

23. SIGNATURE

H. M. Ward M. D. or other

Address: Owings Rd Date signed 12/19/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12113

CERTIFICATE OF DEATH

Reg. Dist. No. 2821

93d

1. PLACE OF DEATH:
County Anne Arundel

City or town Parole
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yrs

Hospital, institution, or street address where death occurred:
South River Rd.

How long in hospital or institution?

3. (a) FULL NAME

CHARLES FRANKLIN LEWIS

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widowed

6.(b) Name of husband or wife Eliza H. Lewis

7. Birth date of deceased (mo., day, yr.) December 17, 1856

8. AGE: Years Months Days If less than one day hrs. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Farmer & Chief Deputy Sheriff

11. Industry or business

Father Louis Lewis

Mother Maryland

14. Maiden name Emily Carrick

15. Birthplace Maryland

16. Informant Mrs. Bessie B. Brashears

Address Parole, Nr Annapolis, Maryland

17. Burial Date thereof 12-28-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Anne's Cemetery

Location Annapolis, Maryland

18. Funeral director Ben L. Hopping and Son

Address 170-172 West St. Annapolis, Maryland

Dec. 28, 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Parole (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No. Annapolis, Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1948, at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1, 1948, to Dec. 25, 1948,

and that I last saw him alive on Dec. 24, 1948.

Immediate cause of death Myocarditis, an. wt. 10.4 lb.

Myocardial Demyelination years.

Due to

Due to

Other conditions Cardiac failure years

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George A. Board
Address Annapolis, Maryland Date signed 12-28-48

M. D. or other



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12114

Reg. Dist. No.

835
334

22

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

City or town.....

Anne Arundel

Odenton

Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

Margaret Hardisty

6. (c) If alive, give age..... years

July 1 - 1860

7. Birth date of

deceased (mo., day, yr.)

8. AGE: Years Months Days If less than one day

88 8 15 hrs. min.

9. Birthplace.....

Odenton Md.

(Town, county, and state)

10. Usual occupation.....

Retired Farmer

11. Industry or business.....

Odenton Md.

12. Name.....

John Rowman

13. Birthplace.....

Odenton Md.

14. Maiden name.....

Eleanor Humphrey

15. Birthplace.....

Odenton Md.

16. Informant.....

Mrs Helen Hattie

Address.....

Odenton Md.

17. Burial.....

Burial Cemetery or crematory

Location.....

Odenton Md.

18. Funeral director.....

Ed & White Jr.

Address.....

Laurel Md.

19. Date rec'd by registrar.....

Dec 18

1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

Md.

County.....

Anne Arundel

City or town.....

Odenton

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 15 - 48

Dec 16 - 48

9 35 P.M.

21. I CERTIFY that death occurred on the date above stated. I have attended deceased from

Sept 15 - 48 to Dec 16 - 48

and that I last saw h. a. alive on Dec 14 - 48

Immediate cause of death.....

Cerebral Infarct

DURATION

1 day

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

Address.....

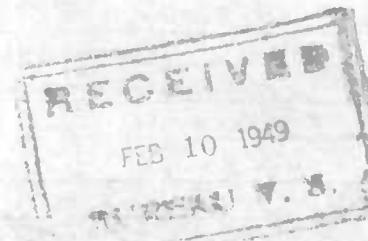
Odenton, Md.

M. D. or other

Date signed

Dec 17 - 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Supply every item of information carefully. Use correct age.
is especially important. Physicians: please write the causes of death clearly and completely.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

182.

12115

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel

City or town Herold Harbor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2800. 1 mo. 27 days

Hospital, Institution, or street address where death occurred:

Holly Trail

How long in hospital or institution?

3. (a) FULL NAME

Donald Frank Matchett

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

November 4, 1948

8. AGE:

Years

Months

Days

If less than one day

0

1

27

hrs.

min.

9. Birthplace

Annapolis, Anne Arundel, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

Frank W. Matchett

12. Name

Washington, D.C.

13. Birthplace

Ella McKenzie

14. Maiden name

Washington, D.C.

15. Birthplace

Mr. Frank W. Matchett (Father)

Address Holly Trail Herold Harbor, Maryland

Burial Crownsville Post Office, Maryland

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory Baldwin Memorial Cemetery

Location Millersville, Maryland

18. Funeral director Ben L. Hopping and Son

Address 170-172 West St. Annapolis, Maryland

Jan. 3, 1949 E. F. Joyce Rose
(date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Herold Harbor (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. Crownsville Post Office

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 31, 1948, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Postmortem Examination on Dec. 31, 1948,
and that I last saw him alive on

Immediate cause of death

Suffocation

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

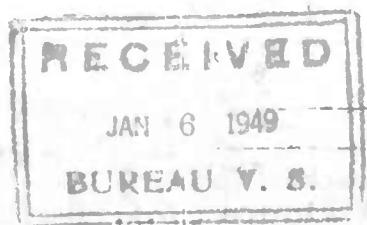
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 12-31-48Where did injury occur? Herold Harbor (City or town) A.A. (County) Md. (State)Injured at home, farm, industry, public place (where?) at homeMeans of injury suffocation Injured at work? DeputyJohn M. Flaherty M.D. medicolegal
Examiner M. D. or otherAddress Anne Arundel Co., Md. Date signed 12-31-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12116

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M
Me

1. PLACE OF DEATH:
 County Anne Arundel
 City or town Severna Creek
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Anne Arundel
 City or town Severna Park
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William E. Mc Ray

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Louise Miller Mc Ray

7. Birth date of deceased (mo. day. yr.) July 4th 1879 6.(c) If alive, give age _____ years

8. AGE: Years 69 Months 4 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Front Royal Va (Town, county, and state)

10. Usual occupation Pet. Pres of Wm E Mc Ray

11. Industry or business Cotton Goods Co.

12. Name Alfred G Mc Ray

13. Birthplace Va

14. Maiden name Annie E Mc Ray

15. Birthplace Va

16. Informant Antrium A Mc Ray

Address Severna Park Md.

17. Burial Date thereof Dec 6th 1948 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt Hebron

Location Winchester Va

18. Funeral director John M Taylor Son

Address Annapolis Md

19. Dec 3 1948 (Date rec'd by registrar) John P French (Signature)
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/48 at 6:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1948 to 12/2/48 and that I last saw him alive on 12/2/48.Immediate cause of death Bronchopneumonia DURATION 3 daysDue to Cerebral Hemorrhage 6 yrs.with Art. HemiplegiaDue to Cardio-Vascular 7 yrs.renal disease

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

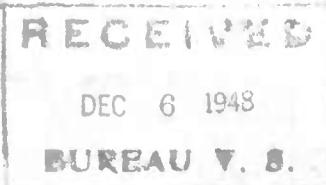
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James P. Martin, M.D. M. D. or other _____Address Annapolis, Md. Date signed 12/3/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12117

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

All his life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

Colored

Married

6. (b) Name of husband or wife

Rosie Campbell

7. Birth date of deceased (mo., day, yr.)

Dec. 13 - 1884

(c) If alive, give age

60

years

8. AGE:

Years

Months

Days

If less than one day

64

0

8

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

Mother Father

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

19.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MD

County

Ad An

City or town

SEVERN

Street No.

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war

(If rural, give LOCATION)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 21, 1948, at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h..... alive on

Immediate cause of death

Coronary & cerebral sudden.

Due to

—

Due to

—

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

City, town, or place

M. D. or other

Address

Glen Burnie, Md.

Date signed

12-21-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County Anne Arundel
City or town Lothian

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Now long in hospital or institution?

3. (a) FULL NAME

Bessie Parker

3. (b) Social Security Number

4. Sex F.	5. Color or race C.	6.(a) Single, married, widowed, or divorced Married
-----------	---------------------	---

6.(b) Name of husband or wife George Parker

6.(c) If alive, give age years Nov. 9. 1902

7. Birth date of deceased (mo. day, yr.)

8. AGE: Years 46 Months 1 Days 1 If less than one day hrs. min.

9. Birthplace Starwood (Town, county, and state)

10. Usual occupation Home

11. Industry or business

12. Name Charles Groeland

13. Birthplace Lothian

14. Maiden name Alberta Brown

15. Birthplace Lothian

16. Informant George Parker

Address Burial Lothian Md

17. (Burial, cremation, or removal) Date thereof Dec-13-1948
(month) (day) (year)

Cemetery or crematory Gut Jim Lee

Location Lothian, Md

18. Funeral director C.W. Hartley & Son

Address Salterville

19. (Date rec'd by registrar) 12/13/48 O.D. Taylor

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Lothian (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war



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- RECEIVED

DEC 16 1948

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12119

94a

21

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Helen E. Phipps

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

July 11th 1896

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Auto mechanic

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

December 1948 to December 6 1948

and that I last saw h. alive on October 15 1948

Immediate cause of death

Ac. Coronary Occlusion

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

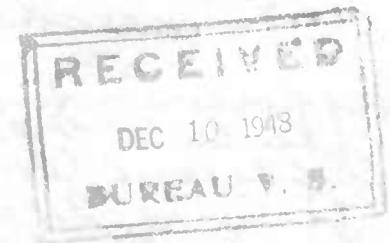
Injured at work?

23. SIGNATURE

M. J. Klawans, M.D. or Other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. It is especially important. Physicians: please write the causes of death clearly and legibly.

8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95a

12120

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel Co.

County

Annapolis

City or town

(If outside city or town limits, write RURAL and give nearest town)

45 Years

How long in above place of death?

Hospital, institution, or street address where death occurred:

76 Clay Street

How long in hospital or institution?

3. (a) FULL NAME

Cathrine Pindell

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Colored Widowed

6.(b) Name of husband or wife Charles Pindell

7. Birth date of deceased (mo., day, yr.) August 27, 1867

8. AGE: Years Months Days If less than one day
81 3 7 hrs. min.9. Birthplace Mt. Zion A.A.C. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

None

11. Industry or business

12. Name Richard Owens

13. Birthplace Mt. Zion A.A.C. Co. Md.

14. Maiden name Priscilla Brown

15. Birthplace Anne Arundel Co. Md.

16. Informant Hattie Smith

Address 76 Clay Street Annapolis, Md.

17. Burial Date thereof 12-7-1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brewer Hill

Location West Street Extended

18. Funeral director Mrs. Charles E. Hicks

Address 43-45 Northwest Street

19. December 6, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel Co.

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

76 Clay Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-December 1948 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 15, 1948, to Dec 4, 1948, and that I last saw her alive on Dec 4th, 1948.

Immediate cause of death

Cardio Vascular Failure

Due to Atrial fibrillation

Due to Atrial fibrillation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

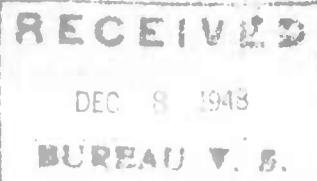
Injured at work?

23. SIGNATURE

Registrar

M. D. or other

Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12121

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel Co.
 County Arnold, Md. near Annapolis
 City or town (If outside city or town limits, write RURAL and give nearest town) Life
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred: Arnold, Md. near Annapolis
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland County Anne Arundel
 City or town Arnold, Md. near Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Arnold, Md. near Annapolis
 (If rural, give LOCATION)

3. (a) FULL NAME
 William A. Porter

3. (b) Social Security Number
 212-14-3196

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Hannah Porter

7. Birth date of deceased (mo., day, yr.) April 20, 1886

8. AGE: Years	Months	Days	It less than one day
62	7	13	hrs. min.

9. Birthplace St. Margrets, Anne Arundel Co. Md.
 (Town, county, and state)

10. Usual occupation Laborer & Gardener

11. Industry or business None

MOTHER FATHER 12. Name James Porter

13. Birthplace St. Margrest, Anne Arundel Co. Md.

MOTHER FATHER 14. Maiden name Jemma Bonds

15. Birthplace St. Margrets, Anne Arundel Co. Md

Hannah Porter

16. Informant.....

Address Arnold Md. Anne Arundel Co. Md

17. Burial Date thereof 12-6-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Calvary Cemetery

Location Arnold, Md. Anne Arundel Co. Md.

18. Funeral director Mrs. Charles E. Hicks

Address 43-45 Northwest Street

19. Dec. 6, 1948
 (Date rec'd by registrar)

MEDICAL CERTIFICATION		
20. DATE OF DEATH December 3, 1948		
21. I CERTIFY that death occurred on the date above stated; that I attended decedent from November 16, 1948, to December 3, 1948, and that I last saw him alive on Dec 3, 1948.		
Immediate cause of death Cerebral Hemorrhage		
DURATION 2 weeks.		
Due to arterial hypertension		
Due to		
Other conditions		
(Include pregnancy, within 3 months of death)		
Major findings at operations		
Date of op.		
Autopsy results		
PHYSICIAN: Please underline the cause to which death should be charged statistically.		

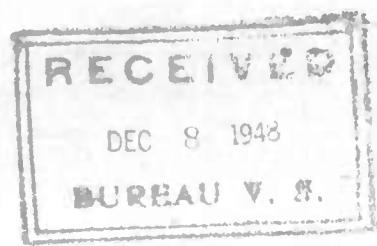
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

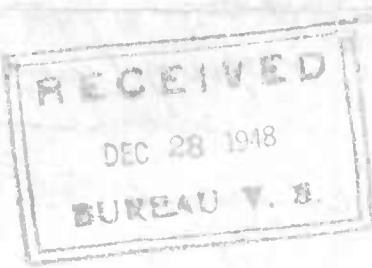
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE R. L. Rubin, M.D. M. D. or other
 Address 155-875 St. Charles St. Date signed 12/5/48





I

9-45-1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12123

Reg. Dist. No.

28

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Anne Arundel County

City or town Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Six months 15 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 6 months, 15 days

3. (a) FULL NAME

JACOB PRICE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Negro Widowed

6. (b) Name of husband or wife unknown (deceased)

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo. day, yr.) (unknown) ABT. 1859

8. AGE: 89 Years Month --- Days --- It less than one day hrs. --- min. ---

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual occupation unknown

11. Industry or business ---

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Hospital Records

Address Crownsville State Hospital

17. Burial Date thereof December 5, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Calvary

Location Arnold, Maryland

18. Funeral director J. B. Johnson

Address Annapolis, Maryland

19. Dec 5, 1948 \$37.00 Due
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Arnold

(If outside city or town limits, write RURAL and give nearest town)

Street No. ---

(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1948 at 5:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17, 1948 19. to December 2, 1948 19.

and that I last saw him alive on December 2, 1948 19.

Immediate cause of death

General Arteriosclerosis

known to us since

6/17/48

Due to

Senile Psychosis

Senile Marasmus

DURATION

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide ---

Date of ---

Where did injury occur? ---

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) ---

Means of Injury ---

Injured at work ---

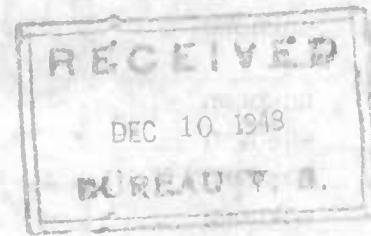
23. SIGNATURE

M. D. or other

Address Crownsville, Maryland

Date signed 12/2/48

bqg 81
4461



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12124

30d

Reg. Dist. No. 1

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Anne Arundel

City or town Green Haven, (Pasadena, P.O. Md.)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

3. (a) FULL NAME

Paul W. Pumphrey

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Elizabeth F. Pumphrey
nee Alvey 6. (c) If slave, give age Deceased

7. Birth date of deceased (mo., day, yr.) January 15, 1881

8. AGE: Years Months Days If less than one day
67 11 8 hrs. min.9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Painter (Retired)

11. Industry or business Schreiber Decorating Co.

12. Name John Wesley Pumphrey

13. Birthplace Prince George County, Md.

14. Maiden name Mary Catherine Lewis

15. Birthplace Washington, D.C.

18. Informant Albert Plews

Address Green Haven, (Pasadena, P.O.) Md.

17. Burial Date thereof Dec. 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Glen Haven

Cemetery or crematory Glen Haven

Location Glen Burnie, Md.

18. Funeral director Thomas W. Singleton

Address Glen Burnie, Md.

19. (Date read by registrar) 12/24/48 12/24/48
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Green Haven, (Pasadena, P.O.) Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 5th. St. & East Shore Drive
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

579-05-4307

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1948 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1948 to Dec 20 1948

and that I last saw her alive on 12/23/48 1948

Immediate cause of death:

Pulmonary Hemorrhage 3 months

Due to: Anoxemia of arch of aorta + Struck

Obj to: Date of op.:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury:

Injured at work?

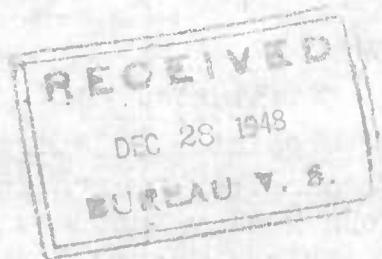
23. SIGNATURE

Gustave H. Peckert, M.D.

M. D. or other

Address Glen Burnie, Md.

Date signed 12/24/48



MARGIN RESERVED FOR BINDING

I

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICALS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County Anne Arundel

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 23

Village or City Lenthum Hts (No.)

544 Forest View Rd.

St:

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Henry K. Reutter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married.
------------	-----------------------	---

6 DATE OF BIRTH

Jan. 6 1882
(Month) (Day) (Year)

7 AGE

66 yrs. 10 mos. 10 days or min.?

If LESS than
1 day hrs.

8 OCCUPATION
 (a) Trade, profession or particular kind of work Motorman B & A R.R.
 (b) General nature of industry business, or establishment in which employed or (employer) Retired.

9 BIRTHPLACE
(State or country)

Baltimore, Md.

10 NAME OF FATHER

John Reutter

11 BIRTHPLACE OF FATHER
(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Sophia Junko

13 BIRTHPLACE OF MOTHER
(State or Country)

Baltimore, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Henry K. Reutter. (wife)

(Address) 544 Forest View Rd. Lenthum Hts

15 Filed 12-6 1948 and Hedrick
T Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 2 1948
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan. 1948 to Dec. 2, 1948,

that I last saw him alive on Nov. 30, 1948,

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Hemorrhage in the Brain.

Contributory
Secondary

(Duration) Immediate
yrs. mos. ds.

Cerebro-Vascular Disease

(Duration) 5 yrs. mos. ds.

(Signed) Anna S. Bellingerha M. D.
Dec. 1948 (Address) Green Burne Rd.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Meadowridge

DATE OF BURIAL 12/6/48

20 UNDERTAKER Leonard J. Luck

ADDRESS 5305 Hayford Rd.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "*Laborer*," "*Foreman*," "*Manager*," "*Dealer*," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "*Asthenia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("Congenital," "Senile," etc.), "*Dropsey*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marasmus*," "*Old Age*," "*Shock*," "*Uraemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12126

CERTIFICATE OF DEATH

Reg. Date No. 25

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

about 30 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Daniel B. Schneppf

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widower

6.(b) Name of husband or wife

Nannie

7. Birth date of deceased (mo., day, yr.)

Dec. 20, 1875

6.(c) If alive, give age

D

years

8. AGE:

72

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

Benjamin Schneppf

12. Name

Benjamin Schneppf

MOTHER FATHER

13. Birthplace

Germany

14. Maiden name

Augusta Schneppf

15. Birthplace

Germany

16. Informant

Mrs. Grace Schneppf

Address

503 Pontiac Ave

17. Burial

Cedar Hill

Cemetery or crematory

Annapolis Blvd

Location

John F. Kennedy Ave

18. Funeral director

John F. Kennedy Ave

Address

Annapolis, Md

19. Date rec'd by registrar

19

Date signed

12-16-48

Reg. Date

12-16-48

Date

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Rear 500 Dorcas Av.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 16 1948 at 9⁰⁰

21. I CERTIFY that death occurred on the date above stated:

Post mortem examination,
all other causes excluded
Dec. 16, 1948

Immediate cause of death

Bullet wound
in right temple

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

at home

Suicide
Brooklyn Heights, A.A. Maryland
12-15-48

Injured at home, farm, industry, public place (where?)

Means of injury

22 cal revolver

Injured at work?

Death

Medical

Examination

M. D. or other

John M. Coffey, M.D.

Annapolis, Md

Date signed

12-16-48

Reg. Date

12-16-48

Date

12-16-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12127

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

Anne Arundel

County

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 $\frac{1}{2}$ days

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 2 $\frac{1}{2}$ days

3. (a) FULL NAME

CHARLES W. SEARS

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Mrs Susie B. Sears

7. Birth date of deceased (mo., day, yr.)

June 10, 1872

6. (c) If alive, give age 69 years

8. AGE:

Years
76Months
6Days
21

If less than one day

hrs.

min.

9. Birthplace

Calvert County, Maryland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name William T. Sears

13. Birthplace Maryland

14. Maiden name Emma Childs

15. Birthplace Maryland

16. Informant Mr. Robert C. Sears (Son)

Address Cedar Park, A.A. Co., Maryland

17. Burial Date thereof 1-2-49
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Zion Methodist Cemetery

Location Mt. Zion, A.A. Co., Maryland

18. Funeral director Ben L. Hopping and Son

Address 170-172 West St. Annapolis, Maryland

19. Date rec'd by Registrar Jan 2, 1949

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Anne Arundel

City or town Parole

(Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. nr Annapolis,

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

220-16-8676

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 31 1948 at 3:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1948 to Dec. 31 1948

and that I last saw him alive on Dec. 31 1948

Immediate cause of death Coronary occlusion

DURATION

2 1/2 days

Due to arteriosclerosis
cardio vascular disease

8-10 p.m.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

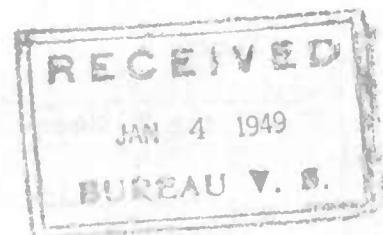
23. SIGNATURE

E. Brownlee

M. D. or other

Address

Annapolis, Md. Date signed 12/31/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12128

CERTIFICATE OF DEATH

28

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel

City or town Patuxent

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sarah Shorter

4. Sex

Female Colored

5. Color or race

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Augustine Shorter

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Mar. 1886

8. AGE: Years

62

Months

-

Days

-

If less than one day

hrs.

min.

9. Birthplace

Millersville post office

(Town, county, and state)

Anne Arundel

10. Usual occupation

Levi Snowden

11. Industry or business

12. Name

Levi Snowden

13. Birthplace

Md.

14. Maiden name

Nancy Snowden

15. Birthplace

Md.

16. Informant

Augustine Shorter

Address

Patuxent

17. Burial, cremation, or removal? Which?

Burial Saffington

Date thereof Dec. 9 1948

(month) (day) (year)

Cemetery or crematory

Saffington Adm'tor of A.C.A.

Location

Baltimore

18. Funeral director

J. B. Jones

Address

J. B. Jones

19. Date rec'd by registrar

Dec. 9 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Anne Arundel

City or town Rural) Patuxent

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 7

1948, at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November

1947, to Dec. 6 1948

end that I last saw her alive on Dec. 6

1948

Immediate cause of death

Hypertension Heart Disease

DURATION

10 Years

Due to Hypertension

Due to

Other conditions Hemiplegia LEFT side

4 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

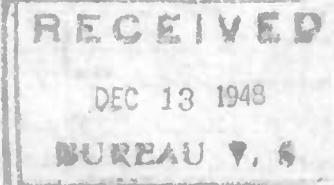
Edward J. Bennett M.D.

M. D. or other

Address

Cambridge Md.

Date signed Dec. 8, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK
Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No.

CERTIFICATE OF DEATH

932
12129

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

3. (a) FULL NAME

Lottie Dennis

4. Sex

female negro

5. Color or race

6.(a) Single, married, widowed, or divorced

widowed

7. Birth date of deceased (mo., day, yr.)

August 29, 1888

6.(c) If alive, give age..... years

8. AGE:

Years 60

Months 8

Days 29

If less than one day

hrs.

min.

9. Birthplace.....

Edgewater Md. A. A. Co.

(Town, county, and state)

10. Usual occupation.....

Domestic

11. Industry or business

Nelson Wells

12. Name.....

A. A. Co. Md.

13. Birthplace

Patrice Wells

14. Maiden name.....

A. A. Co. Md.

15. Birthplace

George Wells

16. Informant.....

Annapolis, Md.

Address

Burial

Date thereof Dec. 30, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory Hopes Chapel

Location Edgewater Md.

Funeral director J. B. Johnson

Address Annapolis, Md. Box 462

Dec. 29, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Anne Arundel

City or town.....

Annapolis

Street No.....

81 Pleasant

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Dec. 27, 1948 at 10 AM

21. I CERTIFY that death occurred on the date above stated; Post mortem Examination

Dec. 27, 1948

Immediate cause of death.....

Acute Cardiac Dilatation sudden

Due to.....

Chronic myocarditis

Due to.....

intoxication

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... Date of op.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work? Death - Medical Examiner

John M. Coffey M.D. Examiner

M. D. or other

Address..... Date signed 12-27-48

VS A15 9-45-15

RECEIVED

DEC 30 1948

BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

12130

Reg. Dist. No. 20

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

Anne Arundel
Edgewater
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

3 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Hester Bush

4. Sex

female

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

Widow

8. (b) Name of husband or wife

Unknown

6. (c) If alive, give age years

T. Birth date of deceased (mo., day, yr.)

Oct. 1883

8. AGE:

65

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Eastern Shore Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

Unknown

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Barris Green

Address

Edgewater Md.

17. Burial

Burial

Date thereof

Dec. 23, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Hopkins Hospital

Location

Edgewater Md.

18. Funeral director

J. A. Haedrich & Son

Address

Galesville Md.

19. Date rec'd by registrar

Dec. 22, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

A. G.

City or town

Edgewater Md.

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

✓

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Dec. 20, 1948*21. I CERTIFY that death occurred on the date above stated: *Postmortem Examination**at Hospital* *Dec. 20, 1948*

Immediate cause of death

Acute Cardiac Failure

Due to

General Cardiac Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John M. Coffey M.D.

M. D. or other

Examiner

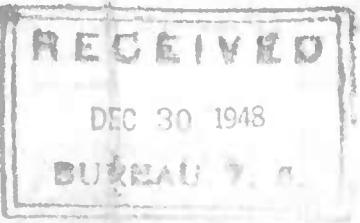
Annapolis, Md.

Date signed

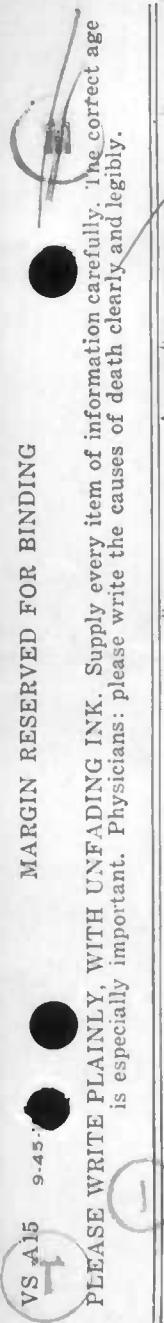
Registrar

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12131

CERTIFICATE OF DEATH

Reg. Dist. No.

23

93d

1. PLACE OF DEATH:

County *P. A.*City or town *Linthicum*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 days*Hospital, institution, or street address where death occurred: *Lynnew Woods*

How long in hospital or institution?

3. (a) FULL NAME

George Washington Snowden

4. Sex

5. Color or race

6.(e) Single, married, widowed, or divorced

Male

col.

Married

6.(b) Name of husband or wife *Sophie Snowden*6.(c) If alive, give age *62* years7. Birth date of deceased (mo. day, yr.) *May 17 1886*

8. AGE:

Years

Months

Days

If less than one day

62

hrs.

min.

9. Birthplace *A. A. Co. Md.*
(Town, county, and state)10. Usual occupation *Laborer*

11. Industry or business

MOTHER

FATHER

12. Name *George - Snowden*

78
19
8431

12132

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County

Anne Arundel Co.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

6 days

Hospital, institution, or street address where death occurred:

Emergency Room of

How long in hospital or institution?

6 days

3. (a) FULL NAME

Robert I. Stewart

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife

Cora Lee Stewart

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

53

Years

Months

Days

It less than one day

8. AGE:

hrs.

min.

9. Birthplace

Balto. Md.

(Town, county, and state)

10. Usual occupation

Chief Engineer

Crown Cork & Seal Co.

Robert Stewart

11. Industry or business

Scotland

12. Name

Florence George

13. Birthplace

England

14. Maiden name

Mrs. Cora Lee Stewart

15. Birthplace

Severna Park A.A. Co. Md.

16. Informant

Burial

Date thereof Jan 3rd 1949

(Burial, cremation, or removal, which?)

Cemetery or crematory

London Park

Location

Balto. Md.

18. Funeral director

William Cook Inc.

Address

127 St. Paul St.

Dec. 31 1948

(Date rec'd by registrar)

A. W. Heidrich

a.s. Registrar

(Date rec'd by registrar)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

12133

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Anne Arundel

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death 18 hours

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

3. (a) FULL NAME

Lydie H. Suttore

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Edward Suttore

7. Birth date of deceased (mo., day, yr.)

May 22 - 1875

8. AGE:

73

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

James Hardisty

13. Birthplace

Maryland

14. Maiden name

Elizabeth Hardisty

15. Birthplace

Maryland

16. Informant

Cora Lee

Address

Harwood Maryland

17. Burial

Buried

(Burial, cremation, or removal. Which?)

Date thereof Dec 8/48

(month) (day) (year)

Cemetery or crematory

Greater Cemetery

Location

Galesville MD

18. Funeral director

J. H. Hodskins & Sons

Address

101 Harmony Street

19. Date rec'd by registrar

Dec 7 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 6

1948 at 9 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 5 1948 to Dec 6 1948

and that I last saw her alive on Dec 6 1948

Immediate cause of death

Bronch Thromb

DURATION

Sudden

Due to Arteriolehem

Due to Myocarditis (Ch.)

Unknown

Other conditions Septicemia

Unknown

(Indicate pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

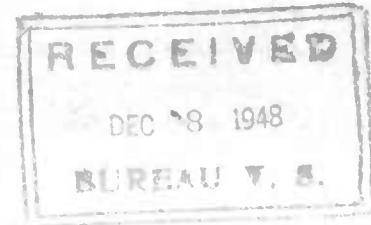
Means of Injury

Injured at work?

3. SIGNATURE

George C. Basl M. D. or other

Address Anne Arundel Dec 7 1948 Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136
Reg. Dist. No. 21

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, street address where death occurred:

105 Prince George St.

How long in hospital or institution?

3. (a) FULL NAME

George E. Taylor

4. Sex

5. Color or race

6. (If single, married, widowed, or divorced)

Male

White

Married

6. (b) Name of husband or wife

Sadie F. Taylor

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

January 21st 1887

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Annapolis, Md. A.A.C.

10. Usual occupation

Plumber

11. Industry or business

William Henry Taylor

12. Name

Maryland

13. Birthplace

Anne M. Taylor

14. Maiden name

Maryland

15. Birthplace

Mrs. Sadie F. Taylor

16. Informant

105 Prince George St. Annapolis

Address

Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

17. Date thereof

(month)

(day)

(year)

Meets of injury

18. Funeral director

John W. Taylor

Address

Dec. 17 1948

(Date rec'd by registrar)

7:00 P.M.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Anne Arundel

City or town

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.

105 Prince George St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 16 1948 at 10 a.m.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1947 to dec 16 1948
and that I last saw him alive on dec 15 1948

Immediate cause of death

Belatedness of disease
Pulmonary tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

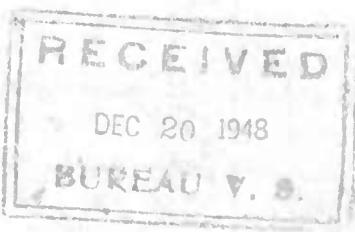
Injured at work?

23. SIGNATURE

George E. Taylor

M. D. or other

Address Annapolis, Md. Date signed Dec 16 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d
12/35

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: *A. A.*
 County: *Annapolis*
 City or town: *Annapolis*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? _____
 Hospital, institution, or street address where death occurred:
251 Hanover st.

How long in hospital or institution? _____

3. (a) FULL NAME *Martha Ellen Thomas -*

4. Sex: *Female* 5. Color or race: *Colored* 6. (a) Single, married, widowed, or divorced: *Widow*

6. (b) Name of husband or wife: *Edward Thomas*

7. Birth date of deceased (mo., day, yr.): *Mar. 1867* 8. (c) If alive, give age: *81* years

8. AGE: Year: *81* Month: *9* Day: *1* If less than one day: *hrs. 0 min.*

9. Birthplace: *A. A. Co.* (Town, county, and state)

10. Usual occupation: *Domestic*

11. Industry or business: *Floyd Galloway*

12. Name: *Floyd Galloway*

13. Birthplace: *A. A. Co.*

14. Maiden name: *Rebecca*

15. Birthplace: *A. A.*

16. Informant: *Mary Ryter*

Address: *257 Hanover st*

17. Burial: *Burial* Date thereof: *Dec. 7 1948* (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: *Brewery Hill*

Location: *Annapolis*

18. Funeral director: *Sam'l A. Johnson*

Address: *Annapolis*

19. Dec'd: *Dec. 7 1948* (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: *Md.* County: *St. of. A.*

City or town: *Annapolis* (If outside city or town limits, write RURAL and give nearest town)

Street No.: *257 Hanover st.* (If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: *Dec. 3* 1948 at 6:30^{AM}

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 3, 1948, to Dec. 3, 1948,

and that I last saw her alive on December 3, 1948.

Immediate cause of death: *Cardiac Failure*

DURATION

Due to: *Hypertensive Cardio Vascular Disease*

Due to: _____

Other conditions: _____

(Include pregnancy within 3 months of death)

Major findings of operations: _____

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury: _____

Injured at work? _____

23. SIGNATURE: *Herbie H. Johnson & C*

M. D. or other

Address: *40 Talbot St.* Date signed: *12/6/48*

RECEIVED

DEC 8 1948

BUREAU F. B. I.

M
I
VS A15
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12136
28

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Anne Arundel
 City or town..... Crownsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 11/15/48 - 12/27/48

Hospital, Institution, or street address where death occurred:..... Crownsville State Hospital

How long in hospital or institution?..... 11/15/48 - 12/27/48

3. (a) FULL NAME

WILLIAM LADDY THOMPSON

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	colored	married

6.(b) Name of husband or wife..... Larace Thompson

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)..... 10/22/1907

8. AGE: Year	Month	Days	If less than one day
41	3	4	hrs. min.

9. Birthplace..... North Carolina
 (Town, county, and state)

10. Usual occupation..... Laborer
 none

11. Industry or business.....

12. Name..... Calvin Thompson
 13. Birthplace..... North Carolina

14. Maiden name..... Martha Smith
 15. Birthplace..... North Carolina

16. Informant..... Hospital Records
 Address..... Crownsville, Md.

17. Burial..... Date thereof..... 12/29/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Calvary
 Location..... Md.

18. Funeral director..... Geo. G. Kelson
 Addressee..... 1303 Presstman St.

19. (Date rec'd by registrar)..... 1/28/48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Baltimore, Maryland, Baltimore City

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1321 Presstman Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 12/27/48

19. 48 at 3:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/15/48 19. 48 to 12/27/48 19.

and that I last saw him alive on 12/27/48

Immediate cause of death..... General Paresis

DURATION
known to us since 11/15/48
Due to: -----
Due to: -----
Other conditions: 666666
(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: -----

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12137

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Baltimore Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary C. Tucker

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widow

6. (b) Name of husband or wife

Samuel P. Tucker

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Aug 28 1880

8. AGE:

Years

Months

Days

If less than one day

68

3

16

hrs.

min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual occupation

house

11. Industry or business

MOTHER FATHER

Jos. Adam Eganwachter

12. Name

Mary Land

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Gordon Catterton

16. Informant

John M. Taylor Son

Address

79 Charles St. Baltimore Md.

17. Burial

Date thereof

Dec 15 1948

(Burial, cremation, or removal? Which?)

(month) (day) (year)

Cemetery or crematory

Western Cemetery

Location

Baltimore Md.

18. Funeral director

Address

John M. Taylor SonAnne Arundel Md.

19. Date rec'd by registrar

12/1/48

19 48

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Anne ArundelCity or town Baltimore Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 81 Charles St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 13th 19 48 at 145221. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11th 19 48 to Dec 13 19 48and that I last saw him alive on Dec 13 19 48

Immediate cause of death

Coronary Thrombosis

Due to

Gr HypertensionDiureticC. SevereObstructionHypertension

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

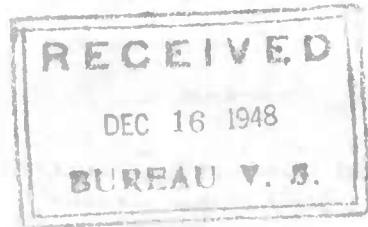
Meane of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Addressee Olive Purser Date signed Dec 13 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12138

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

dead on arrival

3. (a) FULL NAME

Wilbur Tucker

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

Dec 16 - 1908

8. AGE: Years

40

Months

8

Days

If less than one day

hrs.

min.

9. Birthplace

Baltimore, Md

(Town, County, and state)

10. Usual occupation

Laborer

11. Industry or business

Tucker & Tucker

12. Name

Earnest W Tucker

13. Birthplace

Maryland

14. Maiden name

Lillian Leilah

15. Birthplace

Maryland

16. Informant

Earnest W Tucker

Address Riva Maryland

17. Burial

Date thereof Dec 27 / 48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

All Hallows

Location

Birdsboro, Md

18. Funeral director

R. L. Hayslip & Son

Address Annapolis Maryland

19. Date rec'd by registrar

Dec 27 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Anne Arundel

City or town Riva

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 24 1948 at 5¹⁰

21. I CERTIFY that death occurred on the date above stated

Postmortem Examination

Immediate cause of death

Due to

Coronary occlusion sudden

Due to

Coronary sclerosis instant

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work? Deputy medical examiner

Signature J. M. Coffey M.D.

M. D. or other

Address Annapolis Maryland

Date signed Dec 24 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12139

Reg. Dist. No.....

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH:

County ANNE ARUNDEL

City or town GLEN BURNIE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Auguste B. UNGERER.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white Married

6.(b) Name of husband or wife William C. H. Ungerer

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) August 19, 1888

8. AGE: Years Months Days If less than one day
60 3 20 hrs. min.

9. Birthplace CHARLESTON S.C.

(Town, county, and state)

10. Usual occupation HOUSE WORK

11. Industry or business OWN HOME.

MOTHER FATHER 12. Name HENRY MEYER

13. Birthplace Charleston S.C.

14. Maiden name HENRIETTE SCHUETTE.

15. Birthplace BYEMERHAFEN, Germany

16. Informant William C. H. Ungerer

Address 437 CRAIN Highway N.E. Glen Burnie, Md.

17. Burial Date thereof DEC. 11, 1948.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location BROOKLYN, Md. R.F.D.

18. Funeral director Thomas W. Singleton

Address Glen Burnie, Md.

19. 12/11/48 Z. J. Dr. Allen
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County Anne ARUNDEL

City or town GLEN BURNIE

(If outside city or town limits, write RURAL and give nearest town)

Street No. 437 CRAIN Highway N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1948 at 8.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9 AM 1948 to Dec. 9, 8 PM 1948 and that I last saw her alive on Dec. 9, 1948.

and that I last saw her alive on Dec. 9, 1948.

Immediate cause of death Pulmonary edema

Due to cerebral hemorrhage

DURATION 24 hrs.

4 hrs.

Due to

Other conditions Left hemiplegia

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE F.X. Paul J. Dr. Allen

M. D. or other

Address Glen Burnie, Md. Date signed 12/11/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12140

CERTIFICATE OF DEATH

Reg. Dist. No.

28

93d

1. PLACE OF DEATH: Anne Arundel
 County
 City or town Millersville, Md.
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

3. (a) FULL NAME Sophia Marie Urban
MRS. SOPHIE URBAN

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife Anton Urban

7. Birth date of deceased (mo., day, yr.) April 27, 1868

8. AGE: Years 80 Months Days If less than one day hrs. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business unknown

MOTHER FATHER
 12. Name II

13. Birthplace II

14. Maiden name II

15. Birthplace II

16. Informant Rudolph Urban - son
 Address Millersville, Md.

Burial Date thereof 1/2/49
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or cemetery Oak Hill
 Location Horner's Lane, Baltimore, Md.

18. Funeral director Schimunek Funeral Home, Inc.
 Address 2601-3-5 E. Madison St., Baltimore, Md.

19. Dec. 31 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State Md. County Anne Arundel
 City or town Millersville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
 Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war
3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 29 1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPTEMBER 1947 to December 1948

and that I last saw her alive on December 28 1948

Immediate cause of death CONGESTIVE HEART FAILURE

DURATION

Due to ARTERIOSCLEROTIC HEART DISEASE

Due to UNKNOWN

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry F. Zangara M. D. or other

Address Glen Burnie, Md. Date signed 1/29/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a
12141
3

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel Co
 County Brooklyn Park
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 106 5th Ave.
 How long in hospital or institution?..

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Md County Anne Arundel
 City or town Brooklyn MAXWELL Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 106 5th Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

ANNIE OLEVIA WARD

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Widow
---------------	------------------------	---

6.(b) Name of husband or wife William H.

7. Birth date of deceased (mo., day, yr.) March 12, 1882
 6.(c) If above, give age years

8. AGE: Years 66	Months 9	Days 2	If less than one day hrs. min.
------------------	----------	--------	--

9. Birthplace Crisfield, Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER John Emory Tull
 12. Name
 13. Birthplace Crisfield, Md.

14. Maiden name Carrie Davy
 15. Birthplace Crisfield, Md.

16. Informant William M. Ward
 Address 1502 Ralworth Road,

17. Burial Date thereof 12/17/48
 (Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill
 Location Ritchie Highway A.T.F.C.

18. Funeral director Wm Cook Inc.
 Address 6217 St Paul St.

19. Date rec'd by registrar Dec 15 1948 A.W. Hendrix
 (Date rec'd by registrar) (Signature) (Initials) (Date signed)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1948 19. at . M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Deen after death. 10. 19.

and that I last saw h. alive on 19.

Immediate cause of death

Sudden Occlusion
 Due to Previous history of annual
 attacks obtained from
 Due to Dr. Ernest Smith of
 Johns Hopkins Hospital

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE P. J. Giannaldi M.D.

Address 4609 Garrison Hwy Date signed 12-15-48

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The current age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12142

30

Reg. Dist. No.

1. PLACE OF DEATH:
County *Anne Arundel*
City or town *near Fairhaven*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *-*Hospital, institution, or street address where death occurred: *-*How long in hospital or institution? *-*

3. (a) FULL NAME

Vernon Le Roy Watson

3. (b) Social Security Number

4. Sex *male* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *married*

6. (b) Name of husband or wife *Rose Marie Watson*7. Birth date of deceased (mo., day, yr.) *March 2. 1926*6. (c) If alive, give age *18* years8. AGE: Years *22* Months *9* Days *2* If less than one dayhrs. *0* min. *0*9. Birthplace *Owings Chest Co Md*

(Town, county, and state)

10. Usual occupation *Farmer*

11. Industry or business

12. Name *Samuel Watson*13. Birthplace *Md*14. Maiden name *Bertie Catterton*15. Birthplace *Owings Md*16. Informant *Mrs. Samuel Watson*Address *Fairhaven Md*17. Burial Date thereof *Dec. 7. 1948*

(Burial, cremation, or removal. Which?)

Date thereof *(month) (day) (year)*Cemetery or crematory *Mt Harmony*Location *Mt Harmony Md*18. Funeral director *Wm. F. Hutchins*Address *Owings Md.*19. Date rec'd by registrar *12/7/48*(Date rec'd by registrar) *1948*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Anne Arundel*City or town *Fairhaven* (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 4 1948* at *2 1/2 PM*21. I CERTIFY that death occurred on the date above stated: *Post mortem examination**at Bethesda Hospital*

19

Immediate cause of death

Fracture of skull

DURATION

*sudden**Fracture of neck*

sudden

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *accident* Date of *12-4-48*Where did injury occur? *near Fairhaven* (City or town) *A. A. Maryland* (County) (State)Injured at home, farm, industry, public place (where?) *Bob Miller Co. and Hankam*Means of injury *Auto collided with tree* Injured at work? *No*Deputy *John M. Coffey A.D.* medical examinerM. D. or other *Examiner*Address *Annapolis Md.* Date signed *12-4-48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12143
28

CERTIFICATE OF DEATH

305 CB
Reg. Dist. No.

1. PLACE OF DEATH:

Anne Arundel

County

Crownsville

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? three weeks, two days

Hospital, institution, or street address where death occurred:

Crownsville State

How long in hospital or institution? three weeks, two days

3. (a) FULL NAME

JAMES WEST

4. Sex

MALE

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Dolly West

unknown

6. (c) If alive, give age ? years

7. Birth date of deceased (mo. day, yr.) AGT 1872? or 1876

8. AGE: Years 76? Months ? Days ? If less than one day hrs. min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Gordan West

13. Birthplace Georgia

14. Maiden name Emmary West

15. Birthplace Georgia

16. Informant Hospital Records

Address Crownsville State Hospital, Md.

17. Burial Date thereof Dec. 20 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Calvary

Location A.A. County Md.

18. Funeral director Raynor Sanders

Address 1412 E Preston Street

19. Dec. 16, 1948 Reg. No. 19
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Georgia

County unknown

City or town Augusta

(If outside city or town limits, write RURAL and give nearest town)

Street No. unknown

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16/48 19 1. 24 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 24, 1948, to December 16, 1948.

and that I last saw him alive on 12/16/48

Immediate cause of death General Paresis

Due to

Due to

Other conditions Senile Psychosis

known to us since

Nov. 24, 1948

us since

12/24/48

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Crownsville, Md. Date signed 12/17/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12144

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

Anne Arundel

County

Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

3. (a) FULL NAME

THOMAS TERRY WHITE

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Mattie Louise White

7. Birth date of deceased (mo., day, yr.)

June 8, 1880

6.(c) If alive, give age years

8. AGE: Years

58

Months

6

Days

21

less than one day

hrs. min.

9. Birthplace

Westwood, Maryland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

don't know

MOTHER FATHER

12. Name

don't know

13. Birthplace

"

14. Maiden name

"

15. Birthplace

"

16. Informant

Mrs. Mattie White

Address

Washington, D.C.

17. Burial

Date thereof 1-1-49
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory

Trinity Episcopal

Location

Upper Marlboro, Maryland

18. Funeral director

Ritchie Bros.

Address

Upper Marlboro, Maryland

Dec. 29, 1948
(Date rec'd by registrar)

D. French

w Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Anne Arundel

City or town Arnold

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

No.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 29 1948 at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 23 1948 to Dec 29 1948

and that I last saw him alive on Dec 29 1948

Immediate cause of death

Cerebral hemorrhage

Due to arteriosclerosis

cardiovascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. Borosich M.D.

M. D. or other

Address Annapolis MD Date signed Jan 1948

188 Gloucester St.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12145

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County

City or town

Parole

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Henry Colored Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 10 1900

6. (c) If alive, give age years

8. AGE: Years Months Days It less than one day
48 hrs. min.

9. Birthplace West River

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name Henry Williams

13. Birthplace Ind.

14. Maiden name Maggie Jones

15. Birthplace Ind.

16. Informant Maggie Williams

Address Parole

17. Burial Date thereof Dec. 27/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Aranafolia Neck

Location T. O. Johnson

18. Funeral director J. B. Johnson

Address Aranafolia

19. Dec. 27 1948
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

A. F.

City or town

Parole

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 21

1948 at 11:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 2 1948 to Dec 21 1948

and that I last saw her alive on Dec 21 1948

Immediate cause of death

Cerebral vascular accident

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

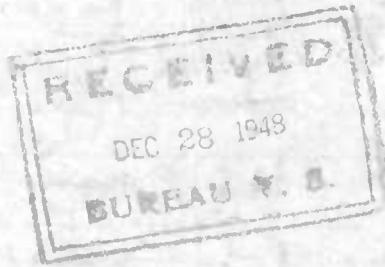
Means of injury

Injured at work?

23. SIGNATURE

Address

G. T. Allen 0200
M. D. or other
Date signed 12-27-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12146
306
28

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel

City or town Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 8 days

3. (a) FULL NAME

HARRY WINTERS

4. Sex

Male

5. Color or race

colored

B.(a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife.....

years

7. Birth date of deceased (mo., day, yr.)

ABT. 1905

8. AGE:

43

Years

Months

Days

If less than one day

**

*** hrs.

**

min.

9. Birthplace.....

Maryland (town unknown)

(Town, county, and state)

10. Usual occupation.....

laborer

none

11. Industry or business

Franklin Winters

FATHER

12. Name.....

Maryland

MOTHER

13. Birthplace

Catherine --last name unknown

unknown

14. Maiden name.....

15. Birthplace

16. Informant.....

Hospital Records

Address

Crownsville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Jan 3, 1949

(month) (day) (year)

Cemetery or crematory

3rd Mt Calvary Cem

Location

A. A. Co.

18. Funeral director.....

Layne Sanders

Address 1412 E. Preston Street

19. (Date rec'd by registrar)

19 X9

D.W. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Baltimore City

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

2219 Hargrove Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

12/30/48

19. 48

12:58P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/23/48

19. 48 to 12/30/48

19. 48

and that I last saw him alive on

12/30/48

19.

Immediate cause of death

General Paresis

Alcoholic Psychosis

DURATION

known to us since

12/23/48

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address.....

Date signed.....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12147 21

1. PLACE OF DEATH:
Anne Arundel
County

City or town..... Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
United States Naval Hospital

How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town nr Annapolis RURAL
Street No. XI Seven Twenty Woodland Beach

(If outside city or town limits, write RURAL and give nearest town)
(If rural, give LOCATION)
WW II

2.(a) If veteran, name war.

3. (a) FULL NAME

JEROME (NONE) ZAVADIL
(last name)

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife ANNA

7. Birth date of deceased (mo., day, yr.) 05-01-03

6.(c) If alive, give age 43 years

8. AGE: Years	Months	Days	It less than one day
45	09	26	hrs. min.

9. Birthplace Baltimore, Md.
(Town, County, and state)

10. Usual occupation Musician (Navy)

11. Industry or business Musician

MOTHER FATHER
12. Name Joseph Zavadil

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant Navy Records

Address USNAVBS., (USS REINA MERCEDES)
Annapolis, Maryland

17. Burial Date thereof Dec. 30, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director Ben L. Hopping and Son

Address 170-172 West St. Annapolis, Maryland

19. Dec 30 1948
(Date rec'd by registrar)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1948 9:02P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from pt. dead on arrival, to pt. dead on arrival, 19.

and that I last saw h. alive on pt. dead on arrival, 19.

Immediate cause of death HEMORRHAGE, Pancreatico-
duodenal artery DURATION Minutes

Due to ULCER, Peptic, Duodenum Unknown

Due to

CARCINOMA, Head of Pancreas;
Laennec's Cirrhosis; Abscess Peri-
toneum (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results as above Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

13. SIGNATURE John M. Claffy, M.D. Deputy Medical Examiner

M. D. or other

Date signed 12-29-48

RECEIVED

JAN 3 1949

BUREAU F. B.